COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF CORRECTION

103 DOC 112

INSTITUTION ASSESSMENT/INSPECTION

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MASSACHUSETTS DEPARTMENT OF CORRECTION	DIVISION: POLICY DEVELOPMENT AND COMPLIANCE UNIT
TITLE: INSTITUTION ASSESSMENT/INSPECTION	NUMBER: 103 DOC 112

Purpose: The purpose of this policy is to establish departmental policy regarding institution assessment/inspections.

References: M.G.L. Chapter 124, section 1 (c), (d), and (q), Chapter 127, section 1 (a), and (b);

Applicability: Staff Public Access: Yes

Location: Central office policy file
Superintendent policy file

Responsible Staff for Implementation and Monitoring of Policy:

- Director of the Policy Development and Compliance Unit
- Assistant Deputy Commissioners
- Superintendents

Effective Date: 06/15/2013

Cancellation: This policy cancels all previous department policy statements, bulletins, directives, orders, notices, rules and regulations regarding institution assessment/inspection which are inconsistent with this policy.

Severability Clause: If any part of this policy is for any reason held to be in excess of the authority of the Commissioner, such decision shall not affect any other part of this policy.

112.01 Institution Assessments

1. In accordance with statutory regulations the Commissioner, through the Policy Development and Compliance Unit (PDCU), shall assess the level of compliance with the established standards within all state correctional facilities.

2. The state standards shall consist of departmental and institution-specific policies and procedures as well as the American Correctional Association (ACA) standards, and other standards deemed appropriate by the Commissioner.

3. State facilities are also required to comply with the established regulations or standards set by the appropriate federal, state, or local authorities in such areas as life, health, fire, and environmental safety, and sanitation.

112.02 Superintendent's Institution Assessment / Inspection Plan

1. Each superintendent shall develop written assessment/inspection procedures to be included in the institution's policy manual which include but are not limited to:

    a. Requiring that the superintendent, deputy superintendent, and designated department heads visit living and activity areas at least weekly to observe living and working conditions, monitor programs, and make general observations on the security, safety, and sanitation of the institution;

    b. Procedures detailing how often and by whom the specific inspection/audit reporting(s) are done.

        i. At a minimum, each institution and division that is audited by the PDCU shall be required to conduct internal audits for each applicable area listed on the Policy Development and Compliance Unit's Intranet site under the heading, "Operational Audit Tools".

ii. Utilizing the above referenced audit tools, designated staff members of a supervisory rank/job title shall audit each area at least annually, and ensure practice reflects current DOC policy and institution procedure.

iii. The results of these internal audits shall be documented in writing and submitted to the superintendent/deputy superintendent or division head for review. Once reviewed, the superintendent/division head or designee shall be required to develop a plan of corrective action with a follow-up date to address any deficiencies cited.

iv. The institution's director of security (or equivalent position) shall keep the completed internal audit forms and plans of corrective action on file for a period of three years.

112.03 PDCU Institution Assessment Plan

1. At least annually, members of the PDCU and other selected departmental staff shall visit each state institution in order to assess each institution's adherence to departmental and institutional policies and procedures as well as to the ACA standards.

2. Superintendents shall ensure, to the degree possible, that all key staff are available for the duration of the audit.

3. Institution staff shall have the opportunity to be orally informed of all significant findings prior to the end of the audit.

4. The following general areas may be assessed at each audit: security, safety, sanitation, food services, medical treatment, maintenance, administration, fiscal, training, personnel, inmate treatment, IMS utilization, and the

accreditation process. The specific areas being assessed may vary from institution to institution as well as from audit to audit depending upon current departmental initiatives or particular areas of concern within a given institution.

5. Purpose of PDCU Audits

The purpose of institution audits are as follows:

a. Provide assistance to management by recommending solutions to problems;

b. Ensure conformity with applicable law, regulations, policies and procedures;

c. Identify weaknesses in internal controls to determine if corrective action is needed before they are revealed by the inmate population through escapes, assaults, disturbances, or litigation;

d. Identify exemplary practices and promote their recognition and replication;

e. Review past and present performance;

f. Promote efficient management practices; and

g. Prevent, detect and report any instances involving mismanagement, waste, abuse, or illegal acts.

6. Auditor Standards

a. Qualifications - The staff assigned to conduct an audit should collectively possess adequate professional proficiency for the tasks required. The Director of the Policy Development and Compliance Unit (PDCU) has the discretion to select auditors.

b. Independence - Each member of the auditing team should maintain an independent attitude and appearance. Independence must be maintained so that conclusions and

recommendations shall be accepted as objective and unbiased.

c. Due Professional Care - Each auditor must exercise due professional care in conducting the audit and in preparing related reports. Good professional judgment must be used in assessing the various operations and programs. Timeliness in reporting and proper handling of sensitive or confidential information is essential.

7. Director of the Policy Development and Compliance Unit (PDCU)

The Director of the PDCU is responsible for coordinating the auditing process throughout the Department of Correction. Pursuant to that task, the director:

a. Serves as a reviewing authority for all departmental audits conducted;

b. Develops and updates the auditing policy and procedures;

c. Annually issues the auditing schedule for all audits;

d. Selects auditors based upon their evaluation skills, ability to communicate, and knowledge of a given operations or program area;

e. Ensures that audits are conducted in a timely and professional manner;

f. Ensures that audit reports are prepared in a timely and professional manner;

g. Maintains an effective follow-up system to ensure that corrective actions are taken;

h. May participate in audits and provides auditing skills training and technical assistance to auditors;

i. Conducts on-site evaluations of auditors;

j. Provides analysis and feedback to affected parties relating to auditing results; and

k. Makes recommendations to the Commissioner for improvements in institution operations, departmental policy and the auditing process.

8. Superintendents

The Superintendents' responsibilities shall include the following:

a. Provide full support and cooperation to the auditors including freedom of access to all property, records, employees, and inmates;

b. Ensure that, barring an emergency, the audit is given priority-one attention for its entire duration;

c. Ensure that all key staff are available for the duration of an audit. Key staff are those most familiar with or responsible for any given operation or program area. If the primary key staff person is not available, a secondary key staff person, who is comparably qualified, must be available to answer questions or assist the auditor;

d. Provide timely initiation and completion of appropriate corrective actions; and

e. Ensure that adequate controls are implemented to avoid the recurrence of deficiencies.

9. Assistant Deputy Commissioners (ADC’s)

The Assistant Deputy Commissioner’s responsibilities shall include the following:

a. Ensure that superintendents are fully responsive during the auditing process, to

the audit findings, and that such findings are responded to in a timely manner;

b. In conjunction with the Commissioner, determine the need for special audits, which may be broad based or limited in scope to a particular operation or program area, or request that particular emphasis be given to an area during an audit; and

c. Analyze the audit reports of their respective facilities to determine if there is a pattern of non-compliance or other significant issue(s).

10. Auditing Process

Pre-audit

a. The Director of the Policy Development and Compliance Unit shall develop and distribute the upcoming fiscal year's auditing schedule via email to all superintendents and executive staff.

b. The audit schedule shall identify the projected month of each institution's audits.

c. At least 30 days in advance of the audit, the Director of the Policy Development and Compliance Unit shall send a written notice to the affected superintendent and Assistant Deputy Commissioner informing them about the audit. The notice shall include the following:

i. The dates of the audit;
ii. Either a general or specific statement concerning the scope of the audit;
iii. A request for the availability of any specific information needed from the review site; and
iv. A request that the superintendent or Assistant Deputy Commissioner respond if there are any additional or special concerns needing examination.

d. If the date(s) of the audit must be changed, the Director of the Policy Development and Compliance Unit or designee shall inform the affected Superintendent and Assistant Deputy Commissioner and shall attempt to reschedule as soon as possible. If the audit is postponed beyond 30 days, another written notice shall be sent.

e. The Commissioner reserves the right to initiate an audit without prior written notice.

11. Audit

Audits consist of a complete examination of one or more components of an institution's physical plant, accreditation process, operations and programs. Each audit shall be conducted by one or more auditors. The chairperson of the audit team shall ensure that:

a. The audit is conducted in accordance with policy and procedure;

b. All findings and recommendations are presented in a written report to senior management;

c. Auditors receive sufficient supervision and guidance; and

d. An overall rating is provided for each area assessed.

12. Scope

a. Generally, audits shall cover at least the areas highly vulnerable to risks, e.g., security, safety, and sanitation.

b. Audits may focus upon institution-specific issues relating to ACES objectives, relevant to 103 DOC 100, Philosophy and Goals, ACA accreditation preparation, areas previously

reported as deficient, or as a result of recent incidents.

c. Audit length may vary depending upon the scope and the findings. The Director of the Policy Development and Compliance Unit has the discretion to determine the length of an audit.

d. Auditors are not constrained from examining areas other than those initially planned if evidence leads them to do so.

e. Institution personnel must grant auditors access to all documents needing review, permit ample latitude for interviewing staff and inmates, and allow inspection of all areas and items of state property. This section is not intended to circumvent established procedures limiting access to certain records, e.g., medical information (HIV), etc. On-site staff should pursue obtaining any necessary permission whenever appropriate.

f. Should conditions exist that limit or restrict an auditor's ability to perform the audit, the chairperson should attempt to informally resolve the issue. If the issue is not resolved informally, the chairperson shall report the problem to the appropriate Assistant Deputy Commissioner and Deputy Commissioner, and shall document it in the working papers and the final written report.

13. Stages of an Audit

There are five interrelated stages to an audit. The order in which they are performed may vary from time to time:

a. PREPARATION
b. EXAMINATION
c. EVALUATION
d. REPORTING
e. FOLLOW-UP

14. Preparation

The auditors should familiarize themselves with the previous audit's findings and with other relevant information such as recent incidents, trends observed, and the Department of Public Health's inspection report(s).

15. Examination

This stage involves collecting data, touring the physical plant, and interviewing staff and inmates.

a. The chairperson shall meet with the other auditors to brief them on the audit plan. This meeting should include a discussion of the time frames, objectives, division of labor, manner of sampling (number, time span reviewed), persons to be interviewed, and processes to be observed. Emphasis should be placed on being as unobtrusive as possible.

b. Key on-site staff, as determined by the superintendent, should be afforded the opportunity for full involvement. The chairperson shall inform the key staff that all comments that may alter findings or recommendations shall be investigated and given due consideration.

c. The chairperson and other auditors should arrange with key staff and the superintendent how feedback shall be handled throughout the audit, e.g., the auditors should meet daily to orally apprise institution staff of observations made and provide sufficient details to allow a full understanding. A record of these interim meetings shall be kept with the working papers.

d. The auditors shall consider the objective of each operation or program and their significance to either the institution's or department's mission, assess the level of

risk for something going wrong, review the adequacy of established procedures and prepare specific recommendations accordingly.

16. Evidence

During the examination stage data is collected. This data is considered evidence to support the conclusions contained in the final written report. There are four types of evidence:

a. Physical - Direct observation of people, property, or processes (most reliable);

b. Testimonial - Interviews (least reliable, seek corroboration);

c. Documentary - Files, records, invoices (helpful, but auditors should not spend an undue portion of time reading documents); and

d. Analytical - Making judgments through computations, reasoning, comparisons, etc.

17. Standards of Evidence

Evidence must meet the following three standards in order to be included in the final, written audit report:

a. Sufficiency - There must be enough factual, convincing evidence to lead a person who is not an expert in the area to the same conclusions as the auditor. Sampling sizes, observations, and interviews should give reasonable assurance that the evidence is valid;

b. Reliability - Seek the best documentation possible (e.g., is testimony corroborated by other evidence?); and

c. Relevance - The evidence must be linked to the area and must have a logical, sensible relationship to the issue.

18. Deficiencies

Auditors may investigate and report on any areas needing improvement. Deficiencies include but are not limited to:

a. Deviations from policies, regulations, or ACA standards;

b. Weaknesses in internal controls;

c. Lack of quality controls;

d. Failure to observe accepted standards or adhere to proven established procedures;

e. Lack of operating efficiency;

f. Failure to meet objectives; or

g. Perceived need for improvement in operations or programs.

19. Exemplars

Auditors may report on any significant solutions, successes, and strengths of operations or programs that are exemplary.

20. Serious or Unusual Problems

Should a serious situation or problem manifest itself, the chairperson may halt or redirect the focus of the audit.

Any evidence of fraud, waste, abuse, or illegal acts should be immediately reported to the superintendent and appropriate Assistant Deputy Commissioner, Deputy Commissioner and Commissioner. Should the accusations involve the superintendent they should be reported directly to the appropriate Assistant Deputy Commissioner, Deputy Commissioner and Commissioner.

21. Working Papers

a. The auditors shall prepare a written record of the audit. The format may vary from time to time but shall usually include handwritten notes based upon interviews, observations, and review of documents (there may be computer printouts, logs, etc., any analysis or computations done, any reprinted checklists used, etc.)

b. The chairperson may collect all working papers and submit them along with the final, written report, to the Director of the Policy Development and Compliance Unit. The working paper may be destroyed after the written report is reviewed by the Director of the Policy Development and Compliance Unit.

22. Interviews

There are three types:

a. Entrance - Upon arrival to the institution, the auditors shall meet with the superintendent or designee and any key staff as determined by the superintendent.

The chairperson shall discuss the scope of the audit, describe how it shall be conducted and discuss the time frames including the date and time of the final closeout.

b. Discovery - The auditors may interview staff and inmates. Auditors should strive to interview a representative sample for accuracy; however, they should be as unobtrusive as possible. The auditor should make it clear to the interviewee that notes may be taken.

c. Close-out - The chairperson and other auditors shall offer to hold daily close-outs to review the daily findings and recommendations. The superintendent shall be given the opportunity to be informed of all significant findings prior to the final

close-out. If the status of a finding should change from that orally discussed with the superintendent, the chairperson shall apprise the superintendent prior to submitting the final written report.

23. Evaluation

a. Ongoing from the time of preparation to the time of submitting the final written report, the auditors evaluate the institution. The evaluation is based upon documents reviewed, interviews held, and observations made.

b. The criteria by which the institution is evaluated include but are not limited to Massachusetts General Laws, 103 CMR policy series, 103 DOC policy series, ACA standards, and institutional procedures.

c. Auditors should look for patterns, trends, causes, and effects of perceived problems, or seek to identify innovative practices.

d. The evidence, earlier discussed, shall be collected into a series of findings. The findings shall consider the significance of the deficiency or exemplar and whether or not it should be included in the final, written report, handled informally (verbally), or overlooked.

e. Questions regarding the significance of an issue should be addressed to the chairperson.

i. In determining the relative significance of a deficiency the chairperson may be guided by the following:

- The extent of the problem or pervasiveness;
- The risk to the affected operation or program area;

- The importance of the operation or program to the institution's or Department of Correction's mission;
- Indication of fraud, waste, abuse or illegal acts or anything that might warrant adverse personnel action; or
- Dollar amount involved.

ii. In determining the significance of any exemplary the following factors may be considered:

- Innovativeness;
- Efficient, cost effective use of resources;
- Effectively targets a problem; or
- Can be applied elsewhere.

24. Findings

a. The auditors should strive to provide an overall rating of each area assessed. One of the following ratings should be proposed for the areas audited:

Excellent - All functions are being performed exceptionally, there are superior internal controls, deficiencies are nonexistent or limited in number and not serious, exceeds expectations.

Good - The program is performing all of its vital functions and there are few deficiencies within any function. Internal controls are such that there are limited deficiencies. Overall performance is above an acceptable level.

Acceptable - This is the baseline for the rating system. The vital functions are being performed adequately. Although numerous deficiencies may exist, they do not detract from the acceptable accomplishment of the vital functions. Internal controls are such that there are no performance

breakdowns that would keep the program from continuing to accomplish its mission.

Deficient - One or more of the vital functions of the operation or program are not being performed adequately. There are weak internal controls.

At Risk - The operation or program is impaired to the point that the area is not accomplishing its mission, there are insufficient internal controls.

(The vital functions of a given operation or program shall be determined by the Director of the PDCU or the chairperson).

b. Each rated finding should be substantiated. The commentary should be titled "Issue". Depending upon the circumstances the auditors may structure their assessment by citing:

i. Conditions - State what was found, type of evidence used, extent of the problem, number of cases involved, etc.

ii. Criteria - State what should be found according to policy, regulations, etc. Use precise citations where possible.

iii. Effect – State what are the results or potential consequences of the existing condition.

iv. Cause - Attempt to discern why the condition exists (i.e., training issue, a supervisory issue, etc.).

c. Recommendations

Auditors should specify what required action should be taken as a result of the findings reported. Examples of recommendations to make include the following:

i. Propose a realistic, workable solution;

ii. Propose an interim solution;
iii. Propose further study;
iv. Specify measures to be taken to comply with policy, etc;
v. Give credit where due;
vi. Propose implementation of the practice elsewhere; or
vii. Propose a formal commendation.

25. Reporting

a. A final, written report shall be prepared. The audit report shall include the date it was prepared, who participated as auditors (names, titles, usual place of work), a brief statement of the dates of the audit, name the key personnel attending interviews or otherwise participating, discuss recent events, findings from the previous audit, provide a summary of the specific areas covered, any responses to a Superintendent's or Assistant Deputy Commissioner's request for examination of particular areas, list repeat significant findings, i.e., those deficiencies noted in the previous report that remain deficient (whether for the same or different reasons), propose recommendations, e.g., changes to institutional practices, procedures, or departmental policies, training needed, etc., and detail significant findings.

b. The auditors should place deficient or exemplary findings into perspective and be fair and accurate. Only that information that is adequately supported by sufficient evidence can be included.

c. The report shall be clear, concise, and the conclusions drawn should be specific and not left to inference. The information must be presented so as to persuade the reader of the appropriateness of the conclusion.

d. It is not necessary for the report to comment upon every component of a given area. Rather, for any given operation or

program assessed, unless specified otherwise, the reader can assume that all of the components were assessed but that only those meriting mention are discussed.

e. The chairperson shall ensure that the findings are adequately supported by sufficient, reliable, and relevant evidence rather than by evidence of minor, irrelevant, or insignificant matters.

26. Timeliness and Distribution

a. The chairperson has 30 days from the final close-out to submit the final, written report. Therefore, the auditors must submit to the chairperson their sections for inclusion shortly after the final closeout.

b. The chairperson submits the final, written report to the Director of the Policy Development and Compliance Unit.

c. The Director of the Policy Development and Compliance Unit shall review the report and forward it to the Commissioner with copies to the appropriate Deputy Commissioner and Assistant Deputy Commissioner within 45 days from the date of the final closeout.

d. The Commissioner shall review the report and, within 60 days from the date of the final closeout, send the affected Superintendent a copy of the audit report along with a memorandum discussing the results and requesting that the superintendent respond, in writing within 60 days, to the Director of the Policy Development and Compliance Unit whether contesting the findings or submitting a plan of action. Copies of the Commissioner's memorandum shall be sent to the appropriate Deputy Commissioner, Assistant Deputy Commissioner, and the Director of the Policy Development and Compliance Unit.

e. i. Upon receipt of the Commissioner's memorandum and the audit report, the superintendent has 60 days to review and submit a response in writing. The superintendent may disagree with the findings or may submit a plan of action. Plans of action must identify the responsible staff, what tasks shall be completed, and provide a target date in order to be sufficient. This shall include physical plant comments that relate to tool accountability, life, fire and/or safety issues, etc., in addition to observations noted that can be permanently corrected. In these instances, a plan of action shall also be included in the audit response. For Pre-ACA audit responses as it relates to the standards, it is not necessary for the audit response to address each folder comment, unless the recommendation is not being followed, and in that case, justification on why must be included. If budget or other issues preclude resolution an explanation should be provided. The superintendent should submit the response to the Director of the Policy Development and Compliance Unit with a copy to the appropriate Assistant Deputy Commissioner.

ii. Any areas that are identified as significant repeat deficiencies, i.e., those which were reported in the prior audit's report and remain deficient require a separate written response, submitted within 60 days, to the Commissioner through the appropriate Assistant Deputy Commissioner with a copy to the appropriate Deputy Commissioner and Director of the Policy Development and Compliance Unit. Any such separate response should describe measures being taken to prevent a recurrence and an explanation of why the deficiency was repeated.

f. The Director of the Policy Development and Compliance Unit has 30 days from date of receipt of the superintendent's response to accept or reject the response.

i. If accepted, the response shall be filed appropriately for review at the next audit.

ii. If rejected, the Director of the Policy Development and Compliance Unit shall notify the superintendent, the Assistant Deputy Commissioner, or the appropriate Deputy Commissioner and Commissioner as circumstances warrant.

27. Outside Distribution

Parties not within the established distribution chain described in the previous section may direct requests for copies of audit reports, working papers, and responses to the Commissioner.

28. Audit Report Follow-Up

a. The Director of the Policy Development and Compliance Unit is responsible for informing the Commissioner, appropriate Deputy Commissioner, and the Assistant Deputy Commissioner, of an inadequate response submitted by a superintendent.

b. The Director of the Policy Development and Compliance Unit may conduct a follow-up audit to gauge the rate of progress in a given operation or program area noted to be deficient or poor as a result of either an internal or other audit. The superintendent and appropriate ADC shall be given oral notice prior to any such follow-up audit.

c. The Superintendent is responsible for taking any necessary action to correct deficiencies cited and to improve internal controls.

d. The Assistant Deputy Commissioner is responsible for monitoring the implementation of corrective actions and internal controls.

112.04 Institution Accreditation Process

This section shall provide a framework for establishing an efficient system of data collection and data quality review.

1. Data Collection Periods

   The facility's supporting documentation shall be collected from audit to audit. For example, a facility undergoing their ACA audit in March of 2012 shall have documentation covering the following time frames:

   April 2009 to March 2010
   April 2010 to March 2011
   April 2011 to March 2012

   Once this time frame has been established, it must be adhered to throughout the three years of the accreditation cycle.

2. Data Collection Methods

   Each Superintendent shall be responsible to establish practice for American Correctional Association (ACA) data collection based upon the following guidelines:

   a. Each facility shall establish a system by which responsibility for collecting ACA documentation is disseminated from upper management through line supervisors. The system by which this is accomplished shall include at a minimum, but not be limited to the following:

      i. Data collection shall start immediately following the facilities ACA hearing and continue throughout the three years. Documentation for the third year of the accreditation cycle shall be collected as close to the facilities scheduled Pre-ACA audit as possible, but should never be older than six months.

ii. An ACA steering committee, comprised of the facility ACA coordinator and three to five other members ranging from senior staff to line staff must meet at least monthly. The monthly meeting shall be documented in writing with the committee members in attendance noted and meeting minutes detailed. The minutes shall be maintained for all three years of the accreditation cycle. The steering committee, through the superintendent shall issue a memorandum each year of the accreditation period directing department heads to begin the data collection process for a particular time period (i.e., April 2011 to March 2012, etc.). The memorandum shall inform the individual department head of all of the ACA folders they are required to collect documentation for and the time frame by which the documentation is to be submitted (i.e., three months from the receipt of the memo, etc.). Department heads shall be ultimately responsible for the collection of the data assigned to them. However, the task of collecting the data should be disseminated to supervisors and staff members in the department head's area. In this way, the ACA process will involve all levels of facility staff.

iii. Specific directions shall be attached to these memorandums indicating what information is required for each folder. Information should be disseminated in working ACA folders. A working ACA folder is a folder that includes the ACA standard checklist form, consisting of the language of the standard in question, as well as the documentation required to substantiate the folder.

iv. Typically, documentation shall be gathered to show one sample of a given action for each year of the accreditation period. When a standard calls for daily, weekly, or monthly examples, two consecutive documents shall be used.

v. If a memo to the standard is required, the memo shall be dated at the end of the data collection period (e.g. if there were no uses of force for that collection period and collection period is April to March the memo should be dated March 31st.)

3. Data Quality

a. Once the documentation has been gathered, it shall be forwarded to the ACA steering committee for data quality checks and inclusion into the ACA folder. The committee shall ensure that all documentation gathered is complete, accurate, and appropriate for inclusion into the folder. Highlighting can be completed at the department head level and verified for accuracy by the steering committee.

The facility ACA coordinator shall ensure that the standard folders are maintained in an audit ready format throughout each year of the accreditation cycle. Documentation received from department heads shall be incorporated into the applicable folders as it is received and highlighted appropriately. The documentation shall be placed into the folder section as indicated on the standard checklist sheet. ACA coordinators may wait until the third and final year of the accreditation cycle to replace outdated policy and procedure in the folders. Be sure to include annual review letters each year if required by the standard. Applicable policies and procedures shall be appropriately highlighted.

b. The ACA coordinator shall be responsible for tracking the return of folder documentation. At a minimum, the tracking system shall document the following:

   i. Which department head each standard folder was assigned to data collection.

   ii. The deadline that was established for documentation to be returned.

   iii. When the documentation was returned and if the section for the folder has been completed, and/or documentation that remains outstanding.

   At the end of each data collection period, the ACA coordinator and the steering committee shall issue a report to the superintendent identifying any folders that have not been returned, as well as the status of the entire process.

c. Standard outcome measures shall be compiled for each year of the accreditation cycle. Healthcare outcome measures shall be compiled by the health services administrator (HSA) for ACI facilities. At the end of each accreditation year, the ACA coordinator shall ensure that the outcome measure statistics are compiled on the proper form and available for review for the proper time frame (audit to audit). This information must also be included in a report to the superintendent at the end of each data collection period.

   ACA significant incident summaries and outcome measures shall be completed for each year of the accreditation cycle for submission to ACA. The final year, or third year of the accreditation cycle, shall be given to the auditors at the time of the re-accreditation audit.

   Note: A copy of the annual significant incident summary report and the outcome measures shall be submitted, along with the annual certification letter, through the Director of the Policy Development and Compliance Unit for

review/approval before it is submitted to ACA annually.